



South Carolina Department of Insurance

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BULLETIN NUMBER 2013-12

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations (collectively "Health Insurance Issuers")

FROM: Raymond G. Farmer
Director of Insurance *R. G. F.*

SUBJECT: Transitional Policy for Health Insurance Issuers with Health Insurance Coverage in Effect in the Individual Market and/or the Small Group Market on October 1, 2013 and Special Request for Data from Health Insurance Issuers in the Individual, Small Group, and Large Group Markets

DATE: November 19, 2013

I. PURPOSE

On November 14, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) issued a letter to state Insurance Commissioners announcing a temporary reprieve for non-grandfathered health insurance plans that would otherwise be modified or terminated as a result of the 2014 market reforms provided for in the Patient Protection and Affordable Care Act. The purpose of this bulletin is to prevent further market disruption and to set forth requirements for issuers intending to extend coverage under these health plans. Further, the bulletin will describe procedures for filing any necessary amendments to existing policy forms, rate increase requests and consumer disclosures. Finally, the bulletin includes a special report of data relating to non-grandfathered health insurance coverage that is currently in existence in the individual, small group, and large group markets in South Carolina.

The South Carolina Department of Insurance (Department) anticipates additional federal guidance related to this matter to be released at a further, as yet unknown, date. Given the short period of time between the federal announcement and the initial date upon which these policies may be terminated as a result of noncompliance with the 2014 market reforms, it is the Department's position that guidance for South Carolina's marketplace must be provided for today so that our carriers may effectively make a determination as to whether or not they may be able to continue these plans and, if so, file the necessary policy and/or rate changes to provide for the renewal of these plans in the 2014 calendar year.

Thus, while the Department will continue to monitor developments at the federal level, it is our intention to provide guidance via this bulletin. We do not anticipate substantial deviations as a result of any forthcoming federal guidance. We will provide further guidance that supplements this bulletin via addendum, if necessary, and work with issuers on an individual basis to address any issuer-specific questions or circumstances.

Inasmuch as the transitional policy provides that the federal government will not enforce certain requirements on these policies for a period of time, South Carolina declines to enforce the 2014 market reforms that the federal government will not enforce for these specific policies. South Carolina will instead enforce its own laws during this transitional period. Should any conflicts arise between this bulletin and forthcoming federal guidance, it is the Department's position that this bulletin and state implementation guidelines will control during this transitional period. As a result, issuers should not expect any substantive changes to the standards and guidelines set forth in this bulletin.

II. APPLICABILITY AND SCOPE

For purposes of this bulletin, the terms "health insurance issuer" or "issuer," "health insurance coverage," "small group market," and "individual market" shall have the meaning set forth in South Carolina Code of Laws § 38-71-840. The definition of individual market and small group market are as amended on September 6, 2011 (*see* Bulletin 2011-11).

This bulletin applies to health insurance issuers offering health insurance coverage in the individual and small group markets with coverage in effect on October 1, 2013.

This bulletin is not applicable to grandfathered health insurance plans or excepted benefit plans.

III. TRANSITIONAL POLICY

On November 14, 2013, a temporary reprieve was issued by the federal government for non-grandfathered health plans or policies that would permit issuers to continue coverage that would otherwise need to be modified, terminated or canceled due to the fact that the coverage does not comply with certain market reforms that are scheduled to take effect for plan or policy years starting on or after January 1, 2014. The details of this policy were set forth in a letter from CCIIO to state Insurance Commissioners dated the same day. A copy of this letter is attached as Appendix A.

Under this federal announcement, if certain specified conditions are met, health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2014 will not be considered to be out of compliance with the following federal market reforms which are included in the Public Health Service Act and scheduled to take effect for plan or policy years starting on or after January 1, 2014:

- PHSA §2701 (relating to fair health insurance premiums);
- PHSA §2702 (relating to guaranteed availability of coverage);
- PHSA §2703 (relating to guaranteed renewability of coverage);
- PHSA §2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status) with respect to adults, except with respect to group coverage;
- PHSA §2705 (relating to prohibitions on discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;
- PHSA §2706 (relating to non-discrimination in health care);
- PHSA §2707 (relating to comprehensive health insurance coverage); and
- PHSA §2709, as codified at 42 U.S.C. §300gg-8 (relating to coverage for individuals participating in approved clinical trials).

Copies of the above-referenced sections of the Public Health Service Act are reproduced in Appendix B.

In order for health insurance issuers to elect to continue to offer coverage that would otherwise be terminated or canceled, the health insurance coverage must have been in effect on October 1, 2013. This coverage may be renewed between January 1 and October 1, 2014, meaning that it could stay in effect until October 1, 2015 (depending on the renewal date) without being considered noncompliant with these federal requirements.

IV. SOUTH CAROLINA DEPARTMENT OF INSURANCE REQUIREMENTS

Notice to DOI of Issuer's Decision Regarding the Transitional Policy and Special Report of Related Data

The Department plans to take the action necessary to prevent further market disruption in accordance with the requirements set forth below.

Issuers are requested to inform the Department as to whether or not they intend to extend coverage pursuant to the transitional policy described in Section III. This notice should detail the following information:

- Name of underwriting issuer;
- Application to individual and/or small group market;
- Number of covered lives by market segment (i.e., individual, small group, and large group) that:
 - were enrolled in non-grandfathered coverage as of a specified date (as determined and noted by the issuer); and
 - will now have the option of retaining coverage under this transitional policy; and
- Name and contact information for primary point of contact on this matter.

The above information is requested under the Department's authority to require special reports pursuant to S.C. Code of Laws § 38-13-160. In order to effectively assist consumers that will undoubtedly have an interest as to whether or not they may continue their existing coverage, the Department does plan to release the names of the carriers that will be and will not be offering policyholders the option to renew their non-grandfathered coverage through October 1, 2014. However, the data requested relating to the number of covered lives will not be released at a carrier-specific level as § 38-13-160 requires the Department to keep replies strictly confidential. If any data is released, it will only be on an aggregate level by market segment. Any additional information provided by the issuer that the issuer believes to be proprietary, trade secret, or otherwise not releasable pursuant to the South Carolina Freedom of Information Act must clearly be marked as such.

These responses, and any questions related to this special reporting requirement, should be submitted via email to healthdata@doi.sc.gov with the subject matter: "Non-grandfathered Health Plans." The Department requests that this information be submitted no later than Monday, December 2, 2013 regardless of whether or not the issuer intends to extend coverage pursuant to this transitional policy. If the issuer is unable to make a final determination or produce the required information by that date, the issuer should notify the Department as such and the Department will work with the issuer on an individual basis as necessary. Please note that this reporting deadline does not apply to the submission of the necessary form and/or rate filings associated with this determination.

Issuer's Decision Must Be Applied in a Uniform, Non-discriminatory Manner

Issuers wishing to extend coverage pursuant to the transitional policy shall make the election to follow the transitional policy on a market-wide basis, offering reenrollment or extended coverage to all impacted policyholders in the individual and/or small group market. This offer must be made in a uniform and non-discriminatory manner. The issuer should document their actions in this regard so as to ensure compliance with South Carolina law.

V. FILING REQUIREMENTS AND EXPEDITED FILING REVIEW PROCESS

The Department appreciates that issuers have not filed forms and/or rates to continue non-grandfathered health insurance plans through the 2014 calendar year. As such, the Department will make every effort to expedite the filing review process for any filings needed in order to extend coverage to impacted consumers that have coverage that would otherwise be terminated or canceled as soon as January 1, 2014. What follows are the guidelines for such filings.

Policy Form Changes and Notices to Policyholders

The Department does not anticipate the need for substantial changes to policy forms pursuant to this transitional policy as the majority of these health plans should be non-grandfathered health plans that already comply with the ACA Immediate Market Reforms (as detailed in Bulletin 2013-04, available online at <http://doi.sc.gov/DocumentCenter/View/3040>). The Department recognizes that changes may need to be made to policy forms to address certain items such as annual limits on EHBs, waiting periods of greater than 90 days, or federal mental health parity requirements pursuant to final rules that are effective for plan or policy years beginning on or after July 1, 2014.

Should such changes need to be made, the issuer should submit a form filing to amend the underlying policy form(s) via endorsement and include the following in the filing cover letter:

1. a list of the underlying form(s) to be amended as well as either a copy of the underlying policy form(s) or the state tracking number(s) for the underlying form(s);
2. an explanatory memorandum that details the changes to the underlying form(s); and
3. any variability in the form(s) being submitted for approval.

According to the CCIIO letter, there is the possibility that the transitional policy may be extended beyond the January 1 – October 1, 2014 time period. That, coupled with the limited duration of this transitional relief, does not necessitate the amendment of the renewability or termination provisions in the underlying contract. In lieu of amending these provisions, the issuer can provide notice of the temporary nature of this renewal of coverage via the notice to impacted individuals provided for below.

Issuers are required to provide notice to impacted individuals of the opportunity to renew their coverage under this transitional policy. In an effort to expedite the process for issuers, the Department has drafted a sample notice that, if used in a substantially similar manner, will be deemed to meet the requirements for this notice. A separate notice may be appropriate for policyholders that have not yet received a cancellation/ nonrenewal notice and, further, amendments to the sample notice may be appropriate to address company-specific, market-specific, or other matters. A final copy of the notice(s) with issuer-specific changes should be provided to the Department as a part of the form and/or rate filing for future reference. If the issuer elects to create its own notice(s), the notice(s) will be subject to prior approval as a part of the filing review process. Please note that these sample notices may be subject to public disclosure and posting to the Department's website as a part of our overall effort to help alleviate consumer confusion during this transitional period.

Rate Changes

Any rate requests shall be made pursuant to Bulletin 2011-03 (<http://doi.sc.gov/DocumentCenter/View/2765>) or Bulletin 2011-11 (<http://doi.sc.gov/DocumentCenter/View/2773>), as applicable. Absent federal guidance to the contrary, the issuer should assume that these policies are not subject to the single risk pool requirements for purposes of the ratemaking process.

Rate filing requests below the “unreasonable” threshold established by the U.S. Department of Health and Human Services need not be submitted in HIOS, but may be submitted via SERFF only. A supporting actuarial memorandum must be provided as a part of any rate filing.

General Requirements Applicable to Form and/or Rate Filings under this Bulletin

All filings must be made via SERFF. In addition to the specified items above, the following information must be included with the filing:

1. Filing Description – The filing description must clearly state that the filing has been made to enable the continuation of coverage pursuant to the transitional policy. In addition, the filing description must clearly state whether or not any changes have been made to the form and whether or not rates are impacted by the filing;
2. Cover Letter – The Cover Letter should detail the items noted above as well as any supporting documentation provided for in the filing;
3. Sample Policyholder Notice(s);
4. Completed Form Schedule Tab (if applicable);
5. Completed Rate/ Rule Schedule Tab (if applicable); and
6. Retaliatory Filing Fees (if applicable).

In an effort to limit the filing requirements, issuers are not required to complete the following items as provided for in Bulletin 2003-13: (1) Certificate of Readability; (2) Form SCID 1504; or (3) certification of compliance by an officer of the insurer.

Issuers are encouraged to submit filings as quickly as possible in order to provide consumers with options as soon as possible. Filings following the requirements of this bulletin and containing the information outlined above will be subject to an expedited review process and will be processed as quickly as practical. Upon submission of a filing pursuant to this bulletin, issuers should submit an email to healthdata@doi.sc.gov with the subject matter: “Filing # [INSERT STATE FILING # HERE]” to advise of the submission of the filing in order to be identified quickly as being subject to expedited review.

By submission of a filing pursuant to this bulletin, the issuer acknowledges that it will comply with the requirements of this bulletin, including the provisions applicable to providing notice to all impacted parties and to act in a uniform, non-discriminatory manner by offering re-enrollment to all impacted policyholders in a market.

VI. EFFECTIVE DATE

This bulletin is effective immediately.

VII. QUESTIONS

Questions regarding this bulletin should be submitted via email to healthdata@doi.sc.gov and include the company name and primary point of contact (with phone number and email address) for follow up.

Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are Departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department’s enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.

***CCIO LETTER TO STATE INSURANCE
COMMISSIONERS,
DATED NOVEMBER 14, 2013***

(SEE THE FOLLOWING THREE PAGES)

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November 14, 2013

Dear Insurance Commissioners,

Some individuals and small businesses with health insurance coverage have been notified by their health insurance issuers that their coverage will soon be terminated. We understand that, in some cases, the health insurance issuer is terminating or cancelling such coverage because it would not comply with certain market reforms that are scheduled to take effect for plan or policy years starting on or after January 1, 2014, such as the new modified community rating and essential health benefits package standards.¹ Although affected individuals and small businesses may access quality health insurance coverage through the new Health Insurance Marketplaces, in many cases with federal subsidies, some of them are finding that such coverage would be more expensive than their current coverage, and thus they may dissuaded from immediately transitioning to such coverage.

In light of this circumstance, under the following transitional policy, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, and associated group health plans of small businesses, will not be considered to be out of compliance with the market reforms specified below under the conditions specified below.² We will consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe.

The specified market reforms are the portions of the following provisions of the Public Health Service Act that are scheduled to take effect for plan or policy years starting on or after

¹ Health plans that are grandfathered pursuant to section 1251 of the Affordable Care Act and its implementing regulations are not subject to most market reforms. Because there is no need for transitional relief for such plans, the transitional relief afforded in this document is not applicable to grandfathered health plans.

² The Department of Health and Human Services has conferred with the Departments of Labor and the Treasury with respect to those market reforms with respect to which there is shared jurisdiction. With respect to those market reforms, the Departments of Labor and the Treasury concur with the transitional relief afforded in this document.

January 1, 2014, and any corresponding portions of the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;³
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

The specified conditions are the following:

- The coverage was in effect on October 1, 2013;⁴
- The health insurance issuer sends a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage, or sends a notice to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms. Where individuals or small businesses have already received a cancellation or termination notice, the issuer must send this notice as soon as reasonably possible. Where individuals or small business would otherwise receive a cancellation or termination notice, the issuer must send this

³ We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plans.

⁴ In light of this condition, the transitional relief afforded in this document is not applicable to newly obtained health insurance coverage. It applies only with respect to individuals and small businesses with coverage that was in effect on October 1, 2013; it does not apply with respect to individuals and small businesses that obtain new coverage after October 1, 2013.

notice by the time that it would otherwise send the cancellation or termination notice.

State agencies responsible for enforcing the specified market reforms are encouraged to adopt the same transitional policy with respect to this coverage.

Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Gary M. Cohen", with a stylized flourish at the end.

Gary Cohen
Director
Center for Consumer Information and Insurance Oversight

MARKET REFORMS IMPACTED BY TRANSITIONAL POLICY

SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

(a) In General- A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.'; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg-1)--

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)--

(I) by striking 'health insurance issuer offering health insurance coverage in connection with a group health plan' each place that such appears and inserting 'health insurance issuer offering group or individual health insurance coverage'; and

(II) in paragraph (2)(A)--

(aa) by inserting 'or individual' after 'employer'; and

(bb) by inserting 'or individual health coverage, as the case may be' before the semicolon; and

(iii) in subsection (e)--

(I) by striking '(a)(1)(F)' and inserting '(a)(6)';

(II) by striking '2701' and inserting '2704'; and

(III) by striking '2721(a)' and inserting '2735(a)'; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

(a) Prohibiting Discriminatory Premium Rates-

(1) IN GENERAL- With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market--

(A) such rate shall vary with respect to the particular plan or coverage involved only by--

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) RATING AREA-

(A) IN GENERAL- Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) SECRETARIAL REVIEW- The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating

areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

`(3) PERMISSIBLE AGE BANDS- The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

`(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE- With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

`(5) SPECIAL RULE FOR LARGE GROUP MARKET- If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

`SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

`(a) Guaranteed Issuance of Coverage in the Individual and Group Market- Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

`(b) Enrollment-

`(1) RESTRICTION- A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

`(2) ESTABLISHMENT- A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

`(3) REGULATIONS- The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

`SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

`(a) In General- Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

`SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

`(a) In General- A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

`(1) Health status.

`(2) Medical condition (including both physical and mental illnesses).

`(3) Claims experience.

`(4) Receipt of health care.

`(5) Medical history.

`(6) Genetic information.

`(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

`(8) Disability.

`(9) Any other health status-related factor determined appropriate by the Secretary.

`(j) Programs of Health Promotion or Disease Prevention-

`(1) GENERAL PROVISIONS-

`(A) GENERAL RULE- For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a `wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

`(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR- If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

`(C) CONDITIONS BASED ON HEALTH STATUS FACTOR- If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

`(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS- If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

`(A) A program that reimburses all or part of the cost for memberships in a fitness center.

`(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

`(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

`(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

`(E) A program that provides a reward to individuals for attending a periodic health education seminar.

`(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS- If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

`(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a

discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

“(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

“(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

“(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

“(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows--

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

“(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

“(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

“(k) Existing Programs- Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

“(l) Wellness Program Demonstration Project-

“(1) IN GENERAL- Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

“(2) EXPANSION OF DEMONSTRATION PROJECT- If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

“(3) REQUIREMENTS-

`(A) MAINTENANCE OF COVERAGE- The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that--

`(i) will not result in any decrease in coverage; and

`(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

`(B) OTHER REQUIREMENTS- States that participate in the demonstration project under this subsection--

`(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

`(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

`(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts--

`(I) do not create undue burdens for individuals insured in the individual market;

`(II) do not lead to cost shifting; and

`(III) are not a subterfuge for discrimination;

`(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note); and

`(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

`(m) Report-

`(1) IN GENERAL- Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning--

`(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

`(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

`(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

`(D) the effectiveness of different types of rewards.

`(2) DATA COLLECTION- In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

`(n) Regulations- Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

`SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

`(a) Providers- A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage

against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

`(b) *Individuals*- The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

`SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

`(a) *Coverage for Essential Health Benefits Package*- A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

`(b) *Cost-sharing Under Group Health Plans*- A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

`(c) *Child-only Plans*- If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

`(d) *Dental Only*- This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

`SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

`(a) *Coverage*-

`(1) *IN GENERAL*- If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer--

`(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

`(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

`(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

`(2) *ROUTINE PATIENT COSTS*-

`(A) *INCLUSION*- For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

`(B) *EXCLUSION*- For purposes of paragraph (1)(B), routine patient costs does not include--

`(i) the investigational item, device, or service, itself;

`(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

`(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- `(3) USE OF IN-NETWORK PROVIDERS- If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.*
- `(4) USE OF OUT-OF-NETWORK- Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.*
- `(b) Qualified Individual Defined- For purposes of subsection (a), the term `qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:*
- `(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.*
- `(2) Either--*
- `(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or*
- `(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).*
- `(c) Limitations on Coverage- This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).*
- `(d) Approved Clinical Trial Defined-*
- `(1) IN GENERAL- In this section, the term `approved clinical trial' means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:*
- `(A) FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:*
- `(i) The National Institutes of Health.*
- `(ii) The Centers for Disease Control and Prevention.*
- `(iii) The Agency for Health Care Research and Quality.*
- `(iv) The Centers for Medicare & Medicaid Services.*
- `(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.*
- `(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.*
- `(vii) Any of the following if the conditions described in paragraph (2) are met:*
- `(I) The Department of Veterans Affairs.*
- `(II) The Department of Defense.*
- `(III) The Department of Energy.*
- `(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.*
- `(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.*
- `(2) CONDITIONS FOR DEPARTMENTS- The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines--*

`(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

`(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

`(e) Life-threatening Condition Defined- In this section, the term `life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

`(f) Construction- Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

`(g) Application to FEHBP- Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

`(h) Preemption- Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.'.

SAMPLE NOTICE TO IMPACTED POLICYHOLDERS

[DATE]

RE: Rescission of Notice of [Cancellation/ Termination/ Nonrenewal] of Coverage and Renewal Offer for Policy # _____
[If policy was not previously canceled: Coverage Renewal Offer]
Coverage/Policy Renewal Effective Dates: _____ to _____

Dear Policyholder:

This letter constitutes official notice that the [cancellation/ termination/ nonrenewal] notice that you were issued on _____ for the above-referenced health insurance policy has been rescinded effective immediately. [Name of Issuer] would like to renew your existing health insurance coverage upon the same terms and conditions. As a result, the above-referenced policy will be renewed for one year effective [date]. It will continue in effect for one year from the policy renewal date.

Under the Patient Protection and Affordable Care Act, your health insurance policy is a non-grandfathered policy. As such, it could not be renewed in 2014 because it did not comply with the 2014 ACA insurance market reforms. Recently, transitional relief has been extended to limit market disruptions. This transition policy allows insurers to renew coverage for individuals and small groups that had insurance policies in effect as of October 1, 2013 for an additional year starting between January 1, 2014 and October 1, 2014.

YOUR RENEWAL POLICY WILL CONTAIN THE SAME COVERAGE AS YOUR EXISTING POLICY

Your current policy, when renewed, may not comply with all of the 2014 market reforms and has been exempted from complying with the following 2014 ACA market reforms. [These include, for example:

- Limits on rate variations;
- Prohibitions on preexisting condition exclusions for adults; and
- Coverage of the essential health benefits package.]

For a more complete listing of the 2014 ACA market reforms, please visit www.healthcare.gov.

[This policy provides basically the same benefits you are currently receiving. To comply with applicable law, some changes were made. Those changes are included in the attached amendatory endorsement and are related to: 1) annual policy limits; 2) waiting periods; and 3) new mental health parity requirements.] [PLEASE NOTE THAT THE PREMIUMS FOR YOUR POLICY MAY CHANGE. AT THE TIME WE ISSUED YOUR CANCELLATION NOTICE, WE DID NOT ANTICIPATE CONTINUING THIS POLICY. IF YOU ELECT TO CONTINUE THIS POLICY, IT IS ESTIMATED THAT YOUR RATE MAY INCREASE ____%.] [Insert details about billing delivery, etc. here]. There have been no other significant changes to the coverage under this policy, and your current coverage will remain unchanged and will continue unchanged according to the terms of your current policy for the renewal period noted above.

You may check your Summary of Benefits and Coverage and policy for an explanation of what your policy currently covers.

OTHER COVERAGE OPTIONS

This letter constitutes an offer to renew your existing coverage. You do not have to accept this renewal offer. You have the following additional coverage options:

- You may purchase a 2014-compliant policy from us or another insurer. [Insert details about your product options here].
- You may purchase coverage in the South Carolina insurance market outside the exchange. Please check the South Carolina Department of Insurance (Department's) website for a list of issuers writing off the exchange at www.doi.sc.gov. Your agent may also be able to assist you with identifying your coverage options.
- You may apply for coverage through the federally-facilitated health insurance exchange at www.healthcare.gov. You can also find local assistance (i.e., a list of South Carolina navigators) through the federally-facilitated exchange at localhelp.healthcare.gov or by calling 1-800-318-2596 for additional assistance. Please note that federal subsidies are only accessible through the exchange.

NEXT STEPS

If you would like to accept this renewal offer, you must do the following:

[Insert steps here]

QUESTIONS

We are here to help you. If you need help enrolling or have questions about your services, please call us at [Insert your telephone number]. We can help you Monday through Friday from ____ a.m. to ____ p.m. Our contact information is included below and is also provided on your insurance card.

Sincerely,

[INSERT HERE]

Questions?

[INSERT COMPANY CONTACT INFORMATION HERE]